special forces pension plan

Disability Retirement Benefits Application Form

Use this form to apply for a SFPP disability pension. Two types of disability pensions are available. A **partial disability pension** may be granted when medical evidence indicates that a member is no longer capable of performing the regular duties of his or her job. A **total disability pension** may be granted when medical evidence indicates that the member is permanently unable to engage in any form of gainful employment. The disability assessment will be based on a combination of medical evidence and pension legislation.

Please send this completed form and the Confidential Medical Statement (after completion by your physician(s)) to:
SFPP, c/o Alberta Pensions Services Corporation (APS), 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9. Fax: 780-421-1652

1. Member Information

member first name _____ member middle name _____ member last name _____

member social insurance number _____

member address _____ member address effective date (YYYY/MM/DD) _____

You are only eligible for a disability pension if you commenced contributions to SFPP on or before June 30, 2007.

city, town, village, etc. _____ province _____ postal code _____

country (if outside Canada) _____ phone number _____ ext. _____ country code (if outside Canada/USA) _____

Work ☐ Home ☐ Cell ☐

2. Have you applied for or are you presently receiving

	applied for		receiving	
Long-term disability benefits?	❒ yes	❒ no	❒ yes	❒ no
Workers' Compensation Board (WCB) benefits?	❒ yes	❒ no	❒ yes	❒ no
Canada Pension Plan (CPP) disability benefits?	❒ yes	❒ no	❒ yes	❒ no

3. Definition of Pension Partner

"Pension Partner" means

(i) a person who, at the relevant time, was married to a participant or former participant and had not been living separate and apart from him or her for 3 or more consecutive years, or

(ii) if there is no person to whom subclause (i) applies, a person who, as at and up to the relevant time, had lived with the participant or former participant in a conjugal relationship

(A) for a continuous period of at least 3 years, or

(B) of some permanence, if there is a child of the relationship by birth or adoption;

Persons are living separate and apart

(a) if they are living apart and either of them has the intention to live separate and apart from the other, or

(b) if, before the relevant time,

(i) they had been living separate and apart for any period, and

(ii) that period was interrupted or terminated by reason only that either of them became incapable of continuing to live separate and apart or of forming or having the intention to continue to live separate and apart of that person's own volition,

and the separation would probably have continued if that person had not become so incapable.

If you are not certain how the definition of pension partner applies to you, please contact the Member Services Centre at 1-877-809-SFPP (7377).

Personal information on this form is collected under the authority of section 9.2 of the Alberta *Public Sector Pension Plans Act* and section 33 of the Alberta *Freedom of Information and Protection of Privacy Act* for the purpose of a member applying for disability pension benefits. If you have any questions regarding the collection of this information, please contact the Member Services Centre (MSC) at 1-877-809-SFPP (7377), or write to SFPP, c/o APS 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9.

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According to the definition above, I have a pension partner on the date that I am completing this form (please check one):

- ❑ **YES** ➔If YES, please complete section *4. Pension Partner Information*
- ❑ **NO** ➔If NO, please skip to section *5. Buyback Service in Pay*

4. Pension Partner Information

pension partner's first name | pension partner's middle name | pension partner's last name

pension partner's date of birth (YYYY/MM/DD) | marital status (married/common law) | Please check one: ☐ female ☐ male

5. Buyback Service in Pay

If you are currently paying for buyback service, do you plan to complete your buyback payments?

- ❑ Yes, I will complete my buyback payments.
- ❑ No, I will not complete my buyback payments. Please prorate my service.

If you are currently paying for buyback service, you must complete payment in full within 90 days of your termination date or you will only receive a partial credit of buyback service based on what you paid.

6. Pension Commencement Date

I want my pension to start on:

date (YYYY/MM/DD)

If the date you give is before you stop participating in the Plan, or before SFPP receives your application, your commencement will be adjusted to the closest possible date. We will send you a **Retirement Benefit Statement** with your pension options. This statement will show the commencement date used to calculate those options.

7. Member Authorization

The information on this form is, to the best of my knowledge and belief, complete and accurate. I authorize my physician(s) to release to SFPP, its representative(s) and/or consulting physician(s), any information relating to the medical condition(s) which is the cause of my disability. This information is to be used to evaluate my application for a disability pension only and permission is **NOT** granted for any other use or disclosure.

member's signature | member's name (please print)

Please note:

- You are responsible for the payment of obtaining any information relating to your medical condition.
- **This is an official record that must be signed to be valid.** Mailing and fax information is at the top of page 1. Keep a copy of the completed form for your records.
- If you have questions, please contact the Member Services Centre, toll free at 1-877-809-SFPP (7377).

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The following section must be completed by your employer unless you are applying for a deferred retirement (meaning you previously left your funds with SFPP).

8. Employer Use Only

a) Please explain whether the member is incapable of performing the duties of his or her position.

_____

_____

b) Is the member receiving WCB benefits? ❑ yes ❑ no

If yes, select one:

- ❑ temporary total disability
- ❑ temporary partial disability

c) Is the member receiving long-term disability (LTD) benefits?

_____

d) If there was a leave of absence this year, record the *estimated* service and salary for the leave period.

Service _____ Salary _____

9. Employer Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

employer name	employer number	member's termination date (YYYY/MM/DD)

name of authorized person (please print)	phone number	ext.

signature of authorized person	(YYYY/MM/DD)

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Confidential Medical Statement

The information on this form will assist SFPP in determining eligibility for disability pension benefits for the patient. No information, in whole or in part, will be released to any unauthorized person(s) without the patient's prior written consent. This statement will be held in strictest confidence and used solely to enable an assessment of the patient's disability by an independent medical consultant. The information on this form must be completed by a physician and returned to the patient.
Charges for the completion of this report, if any, are the responsibility of the patient.

1. Patient Information

patient's first name _____ patient's last name _____ pension plan identification number _____

address _____

city, town, village, etc. _____ province/territory _____ postal code _____

2. Physician Information

physician's full name _____ area code _____ phone number _____

address _____

city, town, village, etc. _____ province/territory _____ postal code _____

3. Medical Relationship

a) How long have you been treating the patient? _____

b) When did you start treating the patient for the medical condition(s)? _____

c) When did you last examine the patient? _____

4. Medical Assessment

1. a) What medical condition(s) are preventing the patient from working?

_____

_____

b) What was the date of onset? _____

c) Please list all relevant symptoms _____

_____

_____

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2. Detail your findings on examination. Please attach supporting documentation such as reports, x-rays, or other tests.

3. Please list any medication prescribed as a result of the medical condition(s) described in 1(a).

4. Please list any medical history relating to the medical condition(s) described in 1(a).

5. Describe any relevant medical problems other than the medical condition(s) described in 1(a).

6. Describe any activities that worsen the patient's medical condition(s) described in 1(a).

7. a) Do you consider the patient has become incapable of effectively performing the regular duties of his/her work as a result of his/her physical or mental impairment? ❑ yes ❑ no

   b) Do you consider the patient is suffering from a physical or mental impairment that can reasonably be expected to last for the remainder of the patient's lifetime and prevents the patient from engaging in any gainful occupation? ❑ yes ❑ no

8. The duration of the disability is:
   - ❑ Temporary (reasonable probability for recovery)
   - ❑ Permanent (low probability for recovery)

9. Please provide any additional information.

5. Physician Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

physician's signature

Date (YYYY/MM/DD)